TRICARE Pharmacy Program Medical Necessity Form for Growth Hormone Products (Genotropin, Humatrope, Omnitrope, Saizen)

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This form applies to the TRICARE Pharmacy Program (TPharm). The medical necessity criteria outlined on this form also apply at Military Treatment Facilities (MTFs). The form must be completed and signed by the prescriber.

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- Treatment with growth hormone requires prior authorization on an annual basis. This form does **NOT** fulfill prior authorization requirements. Please see: www.tricare.osd.mil/pharmacy/prior_auth.cfm for more information.
- Growth hormone (somatropin) products on the DoD Uniform Formulary include Norditropin, Norditropin Nordiflex; Nutropin, Nutropin AQ; and Tev-Tropin), as well as Serostim and Zorbtive. **Genotropin, Humatrope, Omnitrope, and Saizen are non-formulary, but available to most beneficiaries at a $22 cost share.**
- The purpose of this form is to provide information that will be used to determine if the use of a non-formulary growth hormone product *instead of a formulary product* is medically necessary. If a non-formulary growth hormone product is determined to be medically necessary, non-Active duty beneficiaries may obtain it at the $9 formulary cost share.
- TRICARE will not cover a non-formulary growth hormone product for Active duty service members unless it is determined to be medically necessary *instead of a formulary growth hormone product*, in which case it will be available to Active duty service members at no cost share.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: TpharmPA@express-scripts.com	MTF	• Non-formulary medications are available at MTFs only if **both** of the following are met: ○ The prescription is written by a military provider or, at the discretion of the MTF, a civilian provider to whom the patient was referred by the MTF. ○ The non-formulary medication is determined to be medically necessary. • Please contact your local MTF for more information. There are no cost shares at MTFs.

Step 1 **Please complete patient and physician information** (Please Print)

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

1. Please indicate which medication is being prescribed:

☐ **Genotropin** ☐ **Omnitrope**

☐ **Humatrope** ☐ **Saizen**

2. Please explain why the patient cannot be treated with a formulary alternative:

Please indicate which of the reasons below applies to each of the formulary alternatives listed in the table. You MUST circle a reason AND supply a specific written clinical explanation for EACH formulary alternative.

Formulary Alternative	Reason	Clinical Explanation
Norditropin, Norditropin Nordiflex	1 2	
Nutropin, Nutropin AQ	1 2	
Tev-Tropin	1 2	
Note: Although all growth hormone (somatropin) products contain the same active ingredient in the same concentration, Serostim and Zorbtive are not considered to be formulary alternatives to Genotropin, Humatrope, Omnitrope, and Saizen. These products are approved and packaged for non-growth related indications and not for growth hormone deficiency (GHD), which may result in waste if used for GHD.		

Acceptable clinical reasons for not using a formulary alternative are:

1. Use of the formulary alternative is contraindicated (e.g., due to hypersensitivity to a preservative or other inactive ingredient).
2. The patient has experienced or is likely to experience significant adverse effects from the formulary alternative (e.g., due to a preservative or other inactive ingredient).

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

Latest revision: October 2007